

No. 2
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15649

ED APR 22 1943

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Sikeston
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes name country _____

3. (a) PRINT FULL NAME Miriam C. Robinson

(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 12
year 43 hour 8:30 minute pr. M.

21. I hereby certify that I attended the deceased from 4-10-43 to _____, 1943; that I last saw her alive on 4-10-43, 1943; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Cauc 6. (a) Single, widowed, married, divorced Married

7. Birth date of deceased: May 9 1870
(Month) (Day) (Year)

8. (b) Name of husband or wife: C.E. Robinson 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death
Hypertensive Heart Disease
& Left Hemiplegia

Due to _____ Duration 6 months

Due to Chronic Nephritis 8 mos

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 73 Months 10 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Mobile, Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name Henry Jackson

13. Birthplace Whitcross 9
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Jackson

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant C.E. Robinson
(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof 4 14 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Cemetery

18. (a) Signature of funeral director Mattie Smith's Son
(b) Address 1287 Main St. Sikeston, Mo.

19. (a) 4-19-43 (b) Louis Lenz
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____

While at work? _____ (Specify type of place) _____ Means of injury _____

23. Signature W. A. General (M. D. or other) _____
Address 204 S. Loemat Charleston, Mo. Signed 4-14-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1315

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 443-558

Date Filed 4-21-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Frank Sparks

Licensed Embalmer No. 3453

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.